NEW YORK STATE | Workers' Compensation Board

REQUEST FOR ASSISTANCE BY INJURED WORKER

This form is not to be used to report an injury. To file a claim, use Form C-3.

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: _____ WCB Case #: _____

Injured Worker Information

☐ Check if new address

Last Name: _____ First Name: _____ MI: ___

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____ Country: USA

Daytime phone #: _____ Email Address: _____

Social Security #: _____ Date of Birth: _____ Gender: ☐ M ☐ F ☐ X

Employer Information

Employer Name: _____

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____ Country: USA

Employer Phone: _____ Federal Tax ID #: _____ The Tax ID # is the (check one): ☐ SSN ☐ EIN

Reason for this Request - Instructions: Check all boxes that apply. Be sure to attach additional forms, medical reports, letters, etc. as required for each checkbox. If the additional information was already submitted do not attach it, but try to identify it in the space at the bottom of this form** by giving the form number or title and the date it was submitted to the Board. Sign and date the form below.

Compensation Payments:

☐ a. I am not working as of _____ and not receiving payments. **Medical documentation indicating disability required.**
Check all that apply:
- ☐ I have filed a claim for a work related injury.
- ☐ My employer is not paying my wages.
- ☐ My claim has not been denied.
- ☐ I have not received a decision barring me from compensation.
- ☐ I have attempted to resolve the issue with the insurer.

☐ b. My payments have been stopped or reduced.

☐ c. I have returned to work as of _____ at full pay.

☐ d. I am making less money than I was before I got hurt. **Attach current pay stub and medical reports from your doctor.**

☐ e. I had two or more employers on the date of accident/injury (concurrent employment).
Attach weekly gross pay before your injury and statement from second employer regarding lost time.

☐ f. I was released from incarceration on _____ and am not receiving payments.
Attach medical report that shows a medical disability and release from custody papers.

☐ g. I have not been paid as directed in the decision filed on _____

Medical Issues:

☐ h. My Prior Authorization Request (PAR) was denied by the insurer**. Attach PAR denial**.
Review by WCB Adjudication can only be requested if:
- ☐ Denial category was Administrative or No Jurisdiction.
  Attach any documents that show why the denial was incorrect.
- ☐ MTG Special Services or MTG Variance PAR was denied for Medical reasons.
- ☐ Non-MTG Over $1,000 PAR was granted in part.

☐ i. My Medication, Durable Medical Equipment, MTG Variance or MTG Special Services PAR was denied or granted in part by the Medical Director's Office. **Attach "Notice of Resolution" regarding treatment.**

☐ j. My disability is now permanent. **Attach Doctor's Report of MMI/Permanent Impairment (Form C-4.3).**
- ☐ Check this box if you were under 25 years of age at time of accident.

☐ k. My medical condition has changed. **Attach medical forms.**

☐ l. My request for medical and transportation reimbursement was denied or has not been addressed. **Attach receipts and Form C-257**.

This form and any attachments must be mailed or emailed to the Workers' Compensation Board.

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Other Issues:

☐ m. I have new information and/or information requested by the Board regarding (**Attach documents**):

☐ n. Other (Explain in the space provided below):

****Document reference information (date, name/title, form ID):** _____

Injured Worker Signature: _____ **Date:** _____

This form and any attachments must be mailed or emailed to the Workers' Compensation Board.

To the Injured Worker - General Information On Using This Form

You may file this form (RFA-1W) and any attachments with the Workers' Compensation Board when you want the Board to take a specific action in your claim, or if you need to alert the Board to any problem or situation that is affecting your claim. Many of the most frequently requested actions/situations are listed as either compensation payment issues (items a through g), or medical issues (items h through l), but you are not limited to those listed. Check all that apply and/or add additional information or explanation in the space provided (m or n).

Complete the identifying information at the top of Form RFA-1W and send the form, WITH ALL APPLICABLE INFORMATION ATTACHED*, to:

Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

Address for Email Filing: wcbclaimsfiling@wcb.ny.gov

The Board will contact you and all parties when it takes action on your claim.

*After each check box you will see the information needed in bold letters. For example, if you are letting the Board know that your disability is now permanent (box j), the information required is, Doctor's Report of MMI/Permanent Impairment (Form C-4.3).

YOU MUST SEND A COPY OF THIS FORM TO THE INSURER(S), OR DIRECTLY TO THE EMPLOYER OR ITS THIRD PARTY ADMINISTRATOR IF THE EMPLOYER IS SELF-INSURED.

If you have any other concerns, you may contact the Board's **ADVOCATE FOR INJURED WORKERS at (800) 580-6665.** Additional information about other Board services may be obtained at the Board's website: **www.wcb.ny.gov.** If you would like to follow your claim online, you can register for eCase using the registration instructions available on the Board's website under the eCase link.

You have the right to legal representation. A lawyer cannot charge you directly for representation in a workers' compensation claim. If there is an award in your claim, any legal fee request must be approved by the Board and will be deducted from the award to you by the insurer and paid directly to the lawyer.

Medical Treatment - Medication/Durable Medical Equipment/Treatment/Test - This form is to be used when a medical request has been denied and you are requesting assistance from the Board regarding one of the reasons listed in box h. If prior authorization has not been requested yet and is required, your health care provider must submit a Prior Authorization Request (PAR). Information regarding submitting Prior Authorization Requests or unpaid medical bills can be found on the WCB website **www.wcb.ny.gov**.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO, OR BY AN INSURER, OR SELF INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that injured worker's provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.